NOTE: Before submitting this completed form to your employer, you may wish to protect the confidentiality of your health information by taping or stapling the form so the health information pages are not visible.

aetna®

Florida Group Business (51 - 100 Eligible Employees) Employee Enrollment/Change Form

Life, Accidental Death & Personal Loss, Disability, Aetna Managed Choice, and Aetna PPO plans are underwritten by Aetna Life Insurance Company. Aetna HMO and Aetna POS plans are underwritten by Aetna Health Inc. Dental plans are provided or administered by Aetna Life Insurance Company.

INSTRUCTIONS: Please be thorough and complete all sections that apply. You are solely responsible for its accuracy and completeness.

Member Aetna ID Number (if available)

Company Name:

Effective Date **Date of Hire**	☐ New Hire ☐ Rehire/Reinstatement ☐ New Group Enrollment ☐ Late Enrollment ☐ Other _____	☐ Change of Coverage ☐ Add Spouse/Dependent Child ☐ Name Change ☐ Other _____	☐ Employee Termination ☐ Remove Spouse/ Dependent Child ☐ Cancel Coverage	☐ COBRA for: ☐ Employee ☐ Dependent Length of Continuation: ☐ 18 ☐ 36 ☐ Other ____ Original Qualifying Event Date _____ Qualifying Event _____

A. Coverage Selection – *Please print clearly, using black ink. (Shaded sections for Employer/Aetna use only)*

Control/Group No.	Suffix	Account	Plan No.	Class Code

1. Medical:

☐ **Aetna HNOnly (HMO OA)** – Plan Option: _____
☐ **Aetna HNOption (POS OA)** – Plan Option: _____
☐ **Aetna Value Pick** – Plan Option: _____
☐ **Aetna Savings Plus (HMO GK)** – Plan Option: _____
☐ **Aetna Managed Choice Open Access** – Plan Option: _____
☐ **Other** – Plan Option: _____

Control/Group No.	Suffix	Account	Plan No.	Class Code

2. Dental – Check one (if applicable):

Standard Plans:
☐ **Aetna Dental® Plan** – Plan Option: _____
☐ **Freedom of Choice:**
☐ Managed Dental *or* ☐ PPO

Voluntary Plans:
☐ **Aetna Dental® Plan** – Plan Option: _____
☐ **Freedom of Choice:**
☐ Managed Dental *or* ☐ PPO

Before today, were you covered under this employer's dental plan? ☐ Yes ☐ No

3. Life and Disability - See specific employee application for Life and Disability coverage.

B. Employee Information – If you are waiving coverage, complete sections B and G.

Social Security Number	Last Name, First Name, M.I.		Job Title
Home Address (PO Box not acceptable)	Apt. No.	City, State	ZIP Code
Work Address (PO Box not acceptable)		City, State	ZIP Code
Home Telephone ( ) -	Work Telephone ( ) -	Primary Language Spoken (Optional)	Number of Dependents including Spouse enrolling for coverage

Salary $ _____	☐ Hourly ☐ Weekly ☐ Monthly	No. of Hours Worked Per Week	Check One ☐ Full-Time ☐ Part-Time ☐ 1099 ☐ Retired ☐ Seasonal ☐ Temporary ☐ COBRA ☐ Union

C. Individuals Covered - ***List individuals for whom you are enrolling or adding/changing/removing coverage. Insert additional sheets if necessary.*** **NOTE FOR MEDICAL AND DENTAL COVERAGE:** While the Federal Patient Protection and Affordable Care Act mandates coverage of dependent children up to age 26, your plan may allow coverage beyond age 26 for medical plans and some dental plans. Some exceptions apply. Please refer to your plan documents or contact your benefits administrator.

1	(**A**)dd (**C**)hange (**R**)emove ___	**Employee Name** (Last, First, M.I.)		Sex (M/F)	Social Security Number		Birthdate (MM/DD/YYYY) / /	
Height	Weight	Incapacitated **Yes** ☐	Coverage Election ☐ Medical ☐ Dental ☐ Life/Disability	If choosing HMO, Primary Office ID #	Current Patient **Yes** ☐	If choosing DMO, Primary Office ID #	Current Patient **Yes** ☐	
2	(**A**)dd (**C**)hange (**R**)emove ___	**Name** (Last, First, M.I.) ☐ **Spouse** ☐ **Domestic Partner**		Sex (M/F)	Social Security Number		Birthdate (MM/DD/YYYY) / /	
Height	Weight	Incapacitated **Yes** ☐	Coverage Election ☐ Medical ☐ Dental ☐ Life	If choosing HMO, Primary Office ID #	Current Patient **Yes** ☐	If choosing DMO, Primary Office ID #	Current Patient **Yes** ☐	
3	(**A**)dd (**C**)hange (**R**)emove ___	**Name** (Last, First, M.I.) ☐ **Child** ☐ **Stepchild** ☐ **Other**		Sex (M/F)	Social Security Number		Birthdate (MM/DD/YYYY) / /	
Height	Weight	Incapacitated **Yes** ☐	Coverage Election ☐ Medical ☐ Dental ☐ Life	If choosing HMO, Primary Office ID #	Current Patient **Yes** ☐	If choosing DMO, Primary Office ID #	Current Patient **Yes** ☐	
4	(**A**)dd (**C**)hange (**R**)emove ___	**Name** (Last, First, M.I.) ☐ **Child** ☐ **Stepchild** ☐ **Other**		Sex (M/F)	Social Security Number		Birthdate (MM/DD/YYYY) / /	
Height	Weight	Incapacitated **Yes** ☐	Coverage Election ☐ Medical ☐ Dental ☐ Life	If choosing HMO, Primary Office ID #	Current Patient **Yes** ☐	If choosing DMO, Primary Office ID #	Current Patient **Yes** ☐	
5	(**A**)dd (**C**)hange (**R**)emove ___	**Name** (Last, First, M.I.) ☐ **Child** ☐ **Stepchild** ☐ **Other**		Sex (M/F)	Social Security Number		Birthdate (MM/DD/YYYY) / /	
Height	Weight	Incapacitated **Yes** ☐	Coverage Election ☐ Medical ☐ Dental ☐ Life	If choosing HMO, Primary Office ID #	Current Patient **Yes** ☐	If choosing DMO, Primary Office ID #	Current Patient **Yes** ☐	
6	(**A**)dd (**C**)hange (**R**)emove ___	**Name** (Last, First, M.I.) ☐ **Child** ☐ **Stepchild** ☐ **Other**		Sex (M/F)	Social Security Number		Birthdate (MM/DD/YYYY) / /	
Height	Weight	Incapacitated **Yes** ☐	Coverage Election ☐ Medical ☐ Dental ☐ Life	If choosing HMO, Primary Office ID #	Current Patient **Yes** ☐	If choosing DMO, Primary Office ID #	Current Patient **Yes** ☐	

D. Dependent Information

List any dependent in Section **C** living at another address.

Name	Address

For Dependent Life Coverage: If age 19 and over and a full-time student, provide the following:

Child Name	School Name	Expected Graduation Date	Number of Credit Hours

E. Coordination of Benefits

Will you have other health insurance at the same time as this coverage? ☐ Yes ☐ No

Name of Person	Carrier Name	Name of Person	Carrier Name

F. Medicare Information

Name of Person	Medicare Part A	Medicare Part B	Medicare Part D	Over Age 65	Disability	End-Stage Renal Disease Effective Date
	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	
	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	

G. Declination/Waiver of Coverage – *Check all that apply.*

I understand I am eligible to apply for this coverage through my employer; however, I am waiving coverage as noted below.

Print Employee Name

☐ **Medical declined for:**
☐ Myself ☐ Spouse ☐ Child(ren)

☐ **Dental declined for:**
☐ Myself ☐ Spouse ☐ Child(ren)

☐ **Life declined for:**
☐ Myself ☐ Spouse ☐ Child(ren)

☐ **Disability declined for:**
☐ Myself

Reason for declining coverage

☐ Spousal group coverage
☐ Parental group coverage
☐ Medicare
☐ Medicaid
☐ Retiree coverage
☐ Another group plan provided by my employer
☐ COBRA coverage
☐ Insurance through another job
☐ TRICARE/Military coverage
☐ Individual coverage – On or Off Exchange
☐ Do not want
☐ Other _____

I certify I have been given the right to apply for this coverage; however, I am waiving coverage as noted above. By declining this group coverage I acknowledge that I and/or my dependents may have to wait until the plan's next anniversary date to be enrolled for group coverage

Please sign here ONLY if you are declining coverage for yourself and/or your dependent(s).
Employee Signature X

Date (Month/Day/Year)

H. Health Questionnaire must be completed when the employer group is:

- **A virgin group;**
- **A newly formed business;**
- **Requesting Life coverage above the Guaranteed Issue amount.**

Health History for Employees and Their Dependents. ***The following information is confidential and will not be seen by or given to your employer.*** Incomplete enrollment forms may delay the effective date of your coverage.

1. Within the last 24 months has anyone applying for coverage consulted, received treatment, by a doctor, psychiatrist, psychologist, or other practitioner or been diagnosed with any of the following conditions or disorders? (Check all that apply.) ☐ Yes ☐ No

a. ☐ Infertility
b. ☐ Endocrine/ Metabolic
c. ☐ Pancreas
d. ☐ Liver/Hepatitis
e. ☐ Immune System (other than HIV)
f. ☐ Blood Disorder
g. ☐ Hemophilia
h. ☐ Epilepsy/Seizure
i. ☐ Heart
j. ☐ Paralysis/Paresis
k. ☐ Diabetes
Date Diagnosed _____
☐ Insulin ☐ Non-Insulin
l. ☐ Tumor/Cyst/Growth
m. ☐ Systemic or Discoid Lupus
n. ☐ Lung or Respiratory
o. ☐ Alcohol or Drug Use
p. ☐ Kidney/Bladder/Urinary
q. ☐ Circulatory/Vascular
r. ☐ Digestive/Stomach/Intestinal
s. ☐ Central Nervous System
t. ☐ Connective Tissue Disorder
u. ☐ Pituitary/Adrenal/Growth Disorder
v. ☐ Birth Defects/Congenital Abnormalities
w. ☐ Arthritis/Bone/Joint/Muscle/Prosthetic Device
x. ☐ Mental/Nervous/Emotional/Eating Disorder
y. ☐ Stroke/Brain/Neurological
z. ☐ Transplant: ☐ Recommended ☐ Pending ☐ Complete
aa. ☐ Advised to have tests, surgery, hospitalization or is treatment needed, or course of treatment not yet determined
bb. ☐ Cancer: Type:_____ Stage _____
☐ Surgery ☐ Chemo ☐ Radiation
cc. ☐ Using: ☐ Crutches ☐ Walker ☐ Wheelchair

2. To the best of your knowledge and belief, is any female currently pregnant? If so, provide due date _____ ☐ Yes ☐ No
Check applicable boxes:
☐ C section planned ☐ Multiple Births Expected (# _____) ☐ Complications: ☐ Past or ☐ Present

3. Has anyone applying for coverage incurred medical expenses in excess of $10,000 in the past 24 months? ☐ Yes ☐ No

4. Has anyone applying for coverage been prescribed medications in the past 12 months? ☐ Yes ☐ No

5. Has anyone applying for coverage been hospitalized or had a surgical procedure in the past 24 months? ☐ Yes ☐ No

6. Does anyone applying for coverage have a known condition that requires on-going treatment, as diagnosed by a licensed member of the medical profession? ☐ Yes ☐ No

7. Do you or your spouse use tobacco products? If so, check the applicable boxes: ☐ Yes ☐ No
☐ Employee: ☐ Cigarettes ☐ Pipe ☐ Cigars ☐ Chewing Tobacco
☐ Spouse: ☐ Cigarettes ☐ Pipe ☐ Cigars ☐ Chewing Tobacco

Has any person listed on this enrollment form been tested positive for exposure to the HIV infection or been diagnosed as having ARC or AIDS caused by the HIV infection or other sickness or condition derived from such infection? ☐ Yes ☐ No

IF YOU ANSWERED "YES" TO QUESTIONS 1 through 7 ABOVE, YOU MUST COMPLETE SECTION I ON THE FOLLOWING PAGE.

I. Health Questionnaire - Details for "Yes" Responses in Section H.

IF YOU ANSWERED "YES" TO QUESTIONS 1 THROUGH 7 IN SECTION H (EXCEPT THE LAST QUESTION IN SECTION H), YOU MUST COMPLETE THE FOLLOWING TO THE BEST OF YOUR KNOWLEDGE AND BELIEF.

Please provide us with FULL DETAILS for each "Yes" answer to any condition(s) checked in Section I. **In addition**, please give details below of last doctor visit and/or physical examination for **ALL** family members listed regardless of the date or reason. *(Insert additional sheets if necessary.)*

Ques. No.	Name of Individual	Condition/Diagnosis/ Treatment	Date of Onset	Date Treatment Ended	Medication Prescribed	Dosage	Still Taking Medication
							☐ Yes ☐ No
							☐ Yes ☐ No
							☐ Yes ☐ No
							☐ Yes ☐ No
							☐ Yes ☐ No
							☐ Yes ☐ No
							☐ Yes ☐ No
							☐ Yes ☐ No
							☐ Yes ☐ No
							☐ Yes ☐ No
							☐ Yes ☐ No
							☐ Yes ☐ No
							☐ Yes ☐ No
							☐ Yes ☐ No
							☐ Yes ☐ No
							☐ Yes ☐ No

If you are providing additional sheets, check here ☐ ***and insert the sheets before sealing this Enrollment form.***

Conditions of Enrollment

On behalf of myself and the dependents listed on Page 2:

1. I acknowledge that by enrolling in the following plans, coverage is provided by the following entities (collectively referred to as "Aetna"):
   - Aetna HMO plans: Aetna Health Inc.
   - Aetna POS plans: Aetna Health Inc.
   - Life, Accidental Death & Personal Loss, disability, dental and all other health coverages: Aetna Life Insurance Company.
2. I understand and agree that my employer's application will determine coverage and that there is no coverage unless and until both the eligible employee enrollment form and employer applications have been accepted and approved by Aetna.
   For life and disability coverages: I understand that the effective date of insurance for myself or for any of my dependents is subject to my being actively at work on that date and that the effective date of insurance for any of my dependents is also subject to the dependent health condition requirements of the benefit plan. Further, I understand that any insurance subject to evidence of good health or medical information will not become effective until Aetna gives its written consent. For Dependent Life, dependents are eligible from 14 days of age up to their 19th birthday, or up to their 23rd birthday, if a full-time student.
3. I understand and agree that this Enrollment/Change Request may be transmitted to Aetna or its agent by my employer or its agent. I authorize any physician, other healthcare professional, hospital or any other healthcare organization ("Providers"), including pharmacies or pharmacy database benefit managers to give to Aetna or its agent information concerning the medical history, prescription utilization history, services or treatment provided to anyone listed on this Enrollment/Change Request form, including those involving mental health and substance abuse. I further authorize Aetna to use such information and to disclose such information to affiliates, Providers, payors, other insurers, third party administrators, vendors, consultants and governmental authorities with jurisdiction when necessary for my care or treatment, payment for services, the operation of my health plan, or to conduct related activities. I have discussed the terms of this authorization with my spouse and competent adult dependents, and I have obtained their consent to those terms. This authorization will remain valid for twenty-four (24) months. I understand that I am entitled to receive a copy of this authorization upon request and that a photocopy is as valid as the original. I may revoke my authorization to disclose nonpublic personal health information at any time. I can make this revocation by completing and returning to Aetna a Revocation of Authorization form that will be sent to me by Aetna upon my request. Aetna also will accept a form developed by my employer or my hand-written request for revocation of authorization. However, the employer form or my request must include all the data elements that are included in Aetna's standard revocation form.

continued on next page

Conditions of Enrollment *(continued)*

4. The plan documents will determine the rights and responsibilities of member(s) and will govern in the event they conflict with any benefits comparison, summary or other description of the plan.
5. I understand and agree that, with the exception of Aetna Rx Home Delivery®, all participating providers and vendors are independent contractors and are neither agents nor employees of Aetna. Aetna Rx Home Delivery, LLC, is a subsidiary of Aetna Inc. The availability of any particular provider cannot be guaranteed and provider network composition is subject to change. Notice of the change shall be provided in accordance with applicable state law.
6. I understand and agree that, with certain exceptions described in the plan documents, HMO and Managed Dental plans only provide coverage for referred benefits, and that, in order to be covered, services must be performed either by a participating primary care physician, primary care dentist, or by the participating specialist, hospital, pharmacy, dentist, or other provider as authorized by a referral from a participating primary care physician.
7. To the best of my knowledge and belief, I represent that all information supplied in this form is true and complete. On behalf of myself and the eligible persons listed herein, I acknowledge that I have read and understand this form in its entirety.

I represent that all information supplied in this form is true and complete. I have read and agree to the Conditions of Enrollment and Misrepresentation on this **Florida** Group Business Employee Enrollment/Change Form.

I understand that, in the event I fail to sign this form within 31 days after the above transaction request or for any reason Aetna does not receive notice of the above transaction request within a reasonable time following the event, my and my dependents' eligibility may be affected.

I am employed by the employer shown on Page 1, and I am working full time at least 25 hours per week for this employer at the regular place of business.

Fraud Statement: Any person who knowingly and with intent to injure, defraud or deceive any insurer files a statement of claim or an application containing any false, incomplete or misleading information is guilty of a felony of the third degree.

Employee Signature	***Employee E-mail Address (optional)***	***Date (Month/Day/Year)***
X		